

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13512

13521 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Calvert</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Co. Hosp.</i>		e. STREET ADDRESS <i>Prince Fred, Md</i>		f. DATE OF DEATH <i>Dec. 18 1958</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Esie M. Brooks</i>	First	Middle	Last	Month	Day	Year		
4. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Sept. 26</i>	9. AGE (In years last birthday) <i>38 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Colonel Gross</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Kent</i>		Address <i>Geneva Gross Olverett Md.</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) <i>from ca of Breasts.</i>		INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from alive on <i>Dec 18 1958</i> , and that death occurred at <i>10:15 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>St. Leonard</i>						
ACTUAL SIGNATURE <i>R. E. Seewell</i>		DATE SIGNED <i>12/18/58</i>						
PHYSICIAN'S NAME (Type)								
22a. BURIAL / CREMATION, REMOVAL (Specify) <i>12-21-58</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM <i>Eastern Chapel</i>		22d. LOCATION (City, town, or county) <i>Oliverett</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Seewell Prince Fred Md</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>DEC 23 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Carroll & Kuhn</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. LUCIA - HABITAT FOR THE HABITAT STATE PROGRAM

CERTIFICATE OF EXISTENCE

NAME	ADDRESS	PHONE NUMBER	EMAIL ADDRESS
John Doe	123 Main Street	(555) 123-4567	john.doe@example.com
Jane Doe	456 Elm Street	(555) 234-5678	jane.doe@example.com
Bob Smith	789 Oak Street	(555) 345-6789	bob.smith@example.com
Susan Johnson	210 Pine Street	(555) 456-7890	susan.johnson@example.com
David Wilson	321 Cedar Street	(555) 567-8901	david.wilson@example.com
Emily Davis	432 Birch Street	(555) 678-9012	emily.davis@example.com
Mark Evans	543 Holly Street	(555) 789-9013	mark.evans@example.com
Karen Green	654 Maple Street	(555) 890-9014	karen.green@example.com
Tommy White	765 Chestnut Street	(555) 901-9015	tommy.white@example.com
Patricia Black	876 Locust Street	(555) 012-9016	patricia.black@example.com
Robert Brown	987 Pine Street	(555) 123-9017	robert.brown@example.com
Sarah Lee	109 Cedar Street	(555) 234-9018	sarah.lee@example.com
James Wilson	210 Birch Street	(555) 345-9019	james.wilson@example.com
Mary Evans	321 Holly Street	(555) 456-9020	mary.evans@example.com
Jeffrey Green	432 Locust Street	(555) 567-9021	jeffrey.green@example.com
Elizabeth Black	543 Chestnut Street	(555) 678-9022	elizabeth.black@example.com
Stephen White	654 Pine Street	(555) 789-9023	stephen.white@example.com
Victoria Lee	765 Cedar Street	(555) 890-9024	victoria.lee@example.com
Matthew Wilson	876 Birch Street	(555) 901-9025	matthew.wilson@example.com
Caroline Evans	987 Holly Street	(555) 012-9026	caroline.evans@example.com
William Green	109 Locust Street	(555) 123-9027	william.green@example.com
Grace Black	210 Chestnut Street	(555) 234-9028	grace.black@example.com
Henry Wilson	321 Pine Street	(555) 345-9029	henry.wilson@example.com
Julia Lee	432 Cedar Street	(555) 456-9030	julia.lee@example.com
Charles Evans	543 Birch Street	(555) 567-9031	charles.evans@example.com
Frances Green	654 Holly Street	(555) 678-9032	frances.green@example.com
George Black	765 Locust Street	(555) 789-9033	george.black@example.com
Albert Wilson	876 Chestnut Street	(555) 890-9034	albert.wilson@example.com
Elizabeth Lee	987 Pine Street	(555) 901-9035	elizabeth.lee@example.com
James Evans	109 Cedar Street	(555) 012-9036	james.evans@example.com
Robert Black	210 Birch Street	(555) 123-9037	robert.black@example.com
Mary Wilson	321 Holly Street	(555) 234-9038	mary.wilson@example.com
Jeffrey Green	432 Chestnut Street	(555) 345-9039	jeffrey.green@example.com
Elizabeth Black	543 Pine Street	(555) 456-9040	elizabeth.black@example.com
Stephen Wilson	654 Cedar Street	(555) 567-9041	stephen.wilson@example.com
Caroline Lee	765 Birch Street	(555) 678-9042	caroline.lee@example.com
Matthew Evans	876 Holly Street	(555) 789-9043	matthew.evans@example.com
Charles Black	987 Chestnut Street	(555) 890-9044	charles.black@example.com
Frances Wilson	109 Pine Street	(555) 901-9045	frances.wilson@example.com
George Lee	210 Cedar Street	(555) 012-9046	george.lee@example.com
Albert Black	321 Birch Street	(555) 123-9047	albert.black@example.com
Mary Evans	432 Holly Street	(555) 234-9048	mary.evans@example.com
Jeffrey Wilson	543 Chestnut Street	(555) 345-9049	jeffrey.wilson@example.com
Elizabeth Lee	654 Pine Street	(555) 456-9050	elizabeth.lee@example.com
Stephen Evans	765 Cedar Street	(555) 567-9051	stephen.evans@example.com
Caroline Black	876 Birch Street	(555) 678-9052	caroline.black@example.com
Charles Wilson	987 Holly Street	(555) 789-9053	charles.wilson@example.com
Frances Lee	109 Chestnut Street	(555) 890-9054	frances.lee@example.com
George Evans	210 Pine Street	(555) 901-9055	george.evans@example.com
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Elizabeth Evans	654 Chestnut Street	(555) 345-9059	elizabeth.evans@example.com
Stephen Black	765 Pine Street	(555) 456-9060	stephen.black@example.com
Caroline Wilson	876 Cedar Street	(555) 567-9061	caroline.wilson@example.com
Charles Lee	987 Birch Street	(555) 678-9062	charles.lee@example.com
Frances Evans	109 Holly Street	(555) 789-9063	frances.evans@example.com
George Black	210 Chestnut Street	(555) 890-9064	george.black@example.com
Albert Wilson	321 Pine Street	(555) 901-9065	albert.wilson@example.com
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Stephen Wilson	765 Chestnut Street	(555) 345-9069	stephen.wilson@example.com
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Charles Evans	987 Cedar Street	(555) 567-9071	charles.evans@example.com
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Jeffrey Black	654 Pine Street	(555) 456-9090	jeffrey.black@example.com
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Stephen Lee	876 Birch Street	(555) 678-9092	stephen.lee@example.com
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Frances Evans	210 Chestnut Street	(555) 890-9094	frances.evans@example.com
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Elizabeth Wilson	765 Chestnut Street	(555) 345-9099	elizabeth.wilson@example.com
Stephen Lee	876 Pine Street	(555) 456-9090	stephen.lee@example.com
Caroline Evans	987 Cedar Street	(555) 567-9091	caroline.evans@example.com
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Frances Evans	210 Holly Street	(555) 789-9093	frances.evans@example.com
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Albert Black	432 Pine Street	(555) 901-9095	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13522 CERTIFICATE OF DEATH

Reg. Dist. No.

13513

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Calvert</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>13</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X West Beach</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Elizabeth W. Cox</i>		First Middle Last		4. DATE OF DEATH <i>December 17 1958</i>		Month	Day	Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i>		8. DATE OF BIRTH <i>1/24/1880</i>		9. AGE (In years lost birthday) <i>78 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Edward L. Claggett</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Hall</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT	
								Address <i>Medical admission chart</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		<i>Coronary occlusion</i>		<i>Generalized arter. sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>St. Leonards, Maryland</i>		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Dec 16, 1958</i> to <i>Dec 17, 1958</i> , that I last saw the deceased alive on <i>Dec 17, 1958</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>St. Leonards, Maryland</i>		DATE SIGNED			
ACTUAL SIGNATURE <i>K. Villarreal</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Dr. Roberto de Villarreal</i>									
22a. BURIAL CEREMONY, KREMENTZ (Specify) <i>Memorial Service</i>		22b. DATE THEREOF <i>12/19/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cem</i>		22d. LOCATION (City, town, or county) <i>Suitland, Md.</i> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wm. Lee & Sons</i>		ADDRESS <i>300 4th St N.E. Wash. D.C.</i>		24a. REC'D BY REGISTRAR <i>DEC 22 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81, BROWNSVILLE - HARRIS CO TRUCKERS ASSOCIATION
HARRIS CO DELEGATE GENERAL

6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG237 1-5-59 et
13523 CERTIFICATE OF DEATH

Reg. Dist. No.

13514

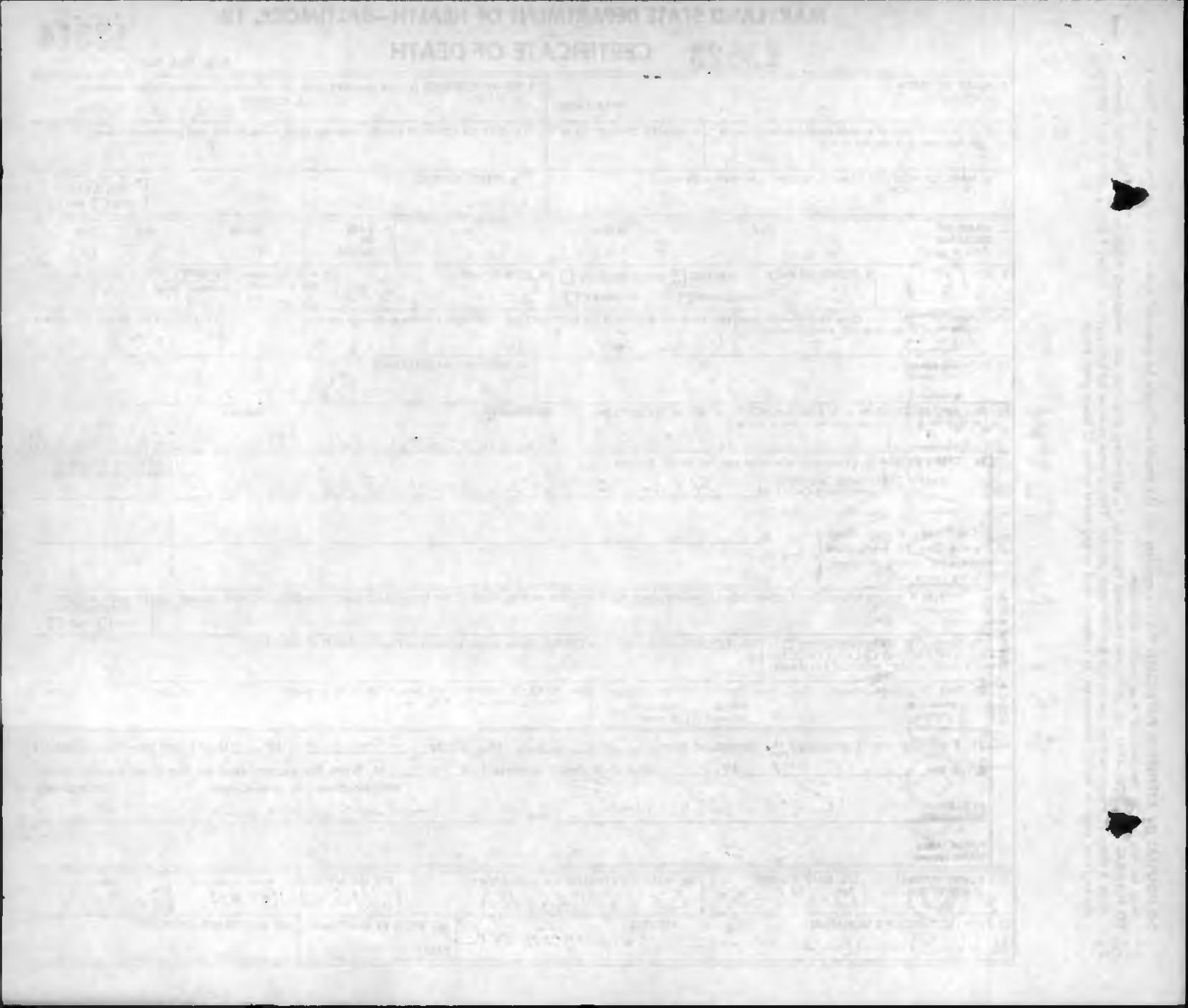
1. PLACE OF DEATH a. COUNTY <i>Calvert County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PRINCE FREDERICK</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <i>At home</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>"At home"</i>		e. STREET ADDRESS <i>Dares Beach, Prince Frederick</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Harry</i>		First <i>FRANCIS</i>	Middle <i>Cox</i>
4. DATE OF DEATH <i>DEC 27 1958</i>		Month <i>DEC</i>	Day <i>27</i>
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>SEPT 13, 1892</i>		9. AGE (In years last birthday) <i>66 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
11. BIRTHPLACE (State or foreign country) <i>WASHINGTON, D.C.</i>		12. IF UNDER 24 HRS. Days <i>0</i>	13. Hours <i>0</i>
14. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		15. FATHER'S NAME <i>JOHN COX</i>	
16. MOTHER'S MAIDEN NAME <i>HELEN OWENS</i>		17. SOCIAL SECURITY NO. <i>NONE</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		ACUTE CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH <i>—</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 26, 1958</i> , to <i>Dec 27, 1958</i> , that I last saw the deceased alive on <i>Dec 26, 1958</i> , and that death occurred at <i>12:30</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>57 LEONARD</i>	
ACTUAL SIGNATURE <i>R. de Villarreal M.D.</i>		DATE SIGNED <i>12/27/58</i>	
PHYSICIAN'S NAME (Type) <i>R. de VILLARREAL M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12-30-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>CONGRESSIONAL</i>
22d. LOCATION (City, town, or county) <i>WASHINGTON, D.C.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Esq. Inc Washington, D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 30 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur E. Thomas</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK - DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13524 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13515

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Calvert</i> <i>MARYLAND</i>		a. STATE <i>Md</i>	b. COUNTY <i>Calvert</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Baltimore</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
<i>Calvert Nursing Home</i>		<i>Grindall</i> <i>Md</i>	
f. NAME OF DECEASED (Type or print)		First <i>annie</i>	Middle <i></i>
		Last <i>Randall</i>	4. DATE OF DEATH
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>House wife</i>		<i>Home</i>	<i>Pic Lee Co Md.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>William J. Ryon</i>		<i>Bennetta Ormon</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
			<i>Mrs Alfred G. Gran</i> <i>Chesapeake Ave</i> <i>Annapolis Md</i>
18. CAUSE OF DEATH [Enter only one cause per line.] (a), (b), and (c.)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>490X</i>		<i>6 hrs</i>	
Conditions, if any, which goe rise to immediate cause (a), stating the underlying cause last. (b) <i>Age</i>			
DUE TO <i>liver</i>			
DUE TO <i>Age</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Had a fall and went unconscious in 3 hrs</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>H.W. Ward</i>		DATE SIGNED <i>January 1965</i>	
EXAMINER'S NAME (Type) <i></i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>12-20-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St James</i>	
22d. LOCATION (City, town, or county) <i>Tracey's GC Co</i>		(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md.</i>		ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>Dec 23 1965</i>
		24b. REGISTRAR'S SIGNATURE <i>John L. Knobell</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEPARTMENT OF TRANSPORTATION STATE OF MARYLAND
ROUTED TO STAGING AT WILMINGTON JACKSON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13516

13525

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE where deceased lived. If institution, Residence before admission a. STATE <i>Calvert</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b e. STREET ADDRESS <i>Deale Beach Md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Co Hospital</i>		d. STREET ADDRESS			
e. FIRST MIDDLE LAST		4. DATE OF DEATH Month Day Year 12 26 1958	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Mary</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/19/99</i>		
9. AGE (In years 1 yr. <input type="checkbox"/> 1 day <input type="checkbox"/> yrs.) <i>59</i>	10. IF UNDER 1 YEAR Months Days Hours Min. <i>0</i>	11. IF UNDER 24 HRS. Hours Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wash DC</i>			
11. BIRTHPLACE (State or foreign country) <i>Wash DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>George Warner</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Hancock</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>331X</i>			
17. INFORMANT <i>Ashley Ward Ches. B. Md</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Hypertension previous</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i> <i>1 day</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fatherly grandfather on left side</i>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>falling down</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Dec 20 1958</i>	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/> <i>19</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Owings, Md.</i>	20f. (City or town) <i>Darnest Rd</i>	(County)	(State)
21. I certify that I attended the deceased from <i>Dec 20 1958</i> to <i>Dec 26 1958</i> , that I last saw the deceased alive on <i>Dec 21 1958</i> , and that death occurred at <i>3:30 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Owings, Md.</i>					
ACTUAL SIGNATURE <i>H. W. Ward</i>	M.D.	DATE SIGNED <i>12/26/58</i>			
PHYSICIAN'S NAME (Type) <i>H. W. Ward</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>12-29-58</i>	22b. DATE THEREOF <i>12-29-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington</i>	22d. LOCATION (City, town, or county) <i>27 Meyer</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home 300-42 NE</i>		ADDRESS <i>Lee Funeral Home 300-42 NE</i>	24a. REC'D BY REGISTRAR DATE DEC 29 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

BY JONATHAN HARRIS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13526 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13517

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Loges 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Chestertown</i> Maryland		a. STATE <i>Md</i>	b. COUNTY <i>Chestertown</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Baltimore</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>John Gray</i>		<i>Baltimore</i>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>Gray</i>
4. DATE OF DEATH		Month <i>12</i>	Day <i>20</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>4/10/39</i>		9. AGE (In years last birthday) <i>39 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labourer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Greensville, N. Carolina</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Address</i>	
17. INFORMANT <i>Miss. Jane Gray, 2242 Darst. Ave. int. Bay</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <i>Cardiac Failure</i>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>7824</i>		INTERVAL BETWEEN ONSET AND DEATH <i>—</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>(b)</i>		DUE TO <i>—</i>	
(b)		DUE TO <i>—</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONCERNING DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Set up in night and dropped dead on floor</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year 3 Hour <i>o. m.</i> <i>14/20</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, etc., office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Darst. Ave.</i> (County) <i>Baltimore</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <i>14/20/58</i>	
22a. BURIAL/CREMATION, REMOVAL (Specify) <i>Carrots</i>		22b. DATE THEREOF <i>12-24-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Carrots</i>		22d. LOCATION (City, town, or county) <i>Darst. Ave.</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. T. Sewell, Bruce Fred.</i>		24a. REC'D BY REGISTRAR DATE <i>REC'D 2 - '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>J. J. J. —</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13527 CERTIFICATE OF DEATH

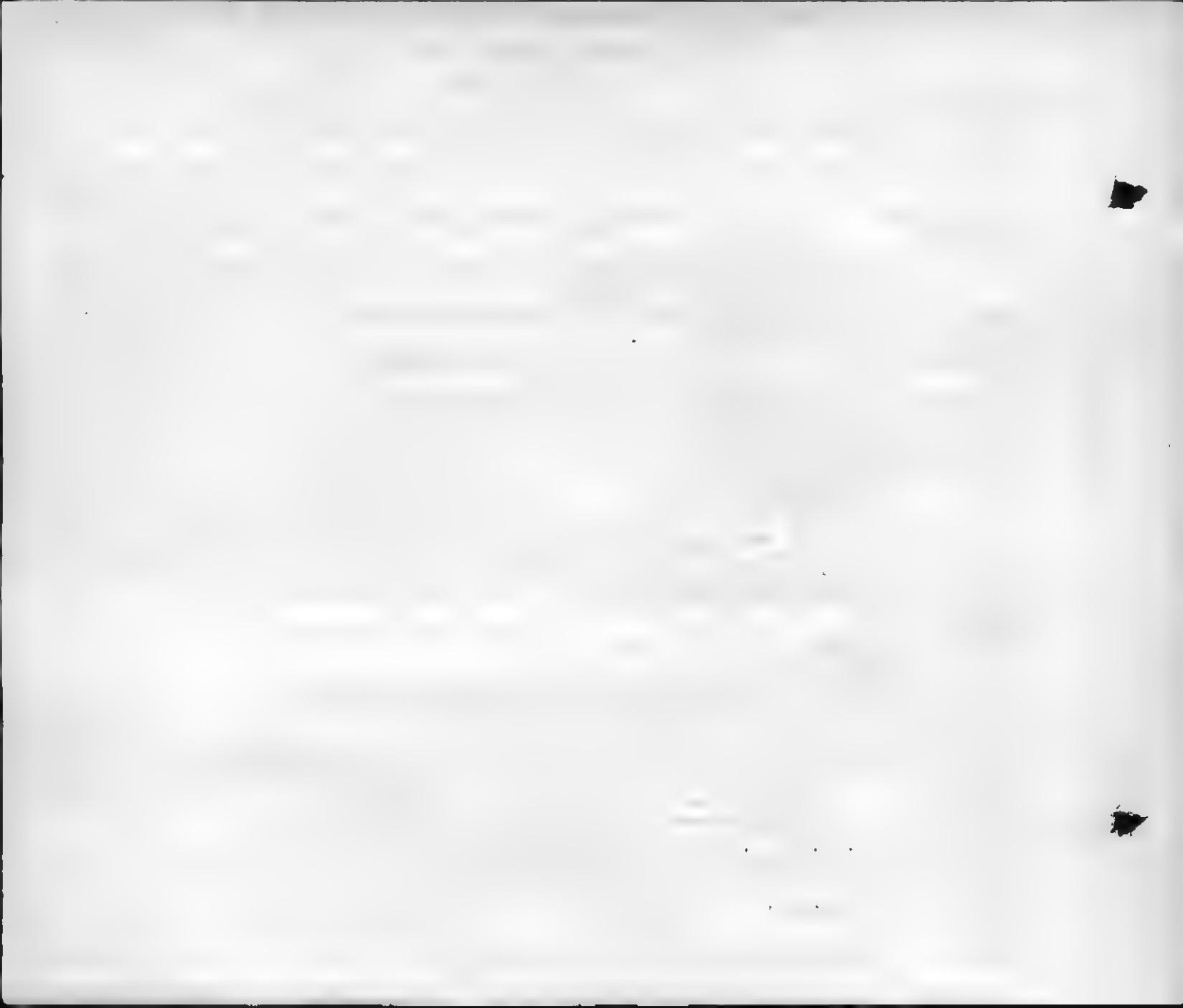
13518

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Cabot MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institutional, residence before admission) o STATE Md b. COUNTY Cabot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Beach</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Beach</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS			
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Wm James Harris</i>	First	Middle	Last		
4. DATE OF DEATH	Month 12	Day 14	Year 1958		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH Oct 22 1882	9. AGE (In years from birthday) 76 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Soldier, Club owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Grocery</i>		11. BIRTHPLACE (State or foreign country) <i>Ill.</i>	
13. FATHER'S NAME <i>Isaac Harris</i>		14. MOTHER'S MARRIED NAME <i>Pauline Herzberg</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1900-1918		16. SOCIAL SECURITY NO. —		17. INFORMANT <i>Mr. W. H. Ward, W. Beach, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Disease</i> 474 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO cause (a), stating the under- lying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Had been sick several years</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>430P.M.</i>			
20c. TIME OF INJURY Month 19 Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Owings, Md. Prince George's Co. Md.</i>	
21. I certify that I attended the deceased from <i>Dec 9, 1958</i> to <i>Dec 14, 1958</i> , that I last saw the deceased alive on <i>Dec 8, 1958</i> , and that death occurred at <i>430P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. W. Ward</i> ADDRESS (Street, city or town, state) <i>Owings, Md.</i> DATE SIGNED <i>12/14/58</i>					
PHYSICIAN'S NAME (Type) <i>H. W. Ward,</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> 22b. DATE THEREOF <i>Dec. 18, 1958</i> 22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National Cemetery</i> 22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hutchins Funeral Home</i>		ADDRESS <i>Owings, Maryland</i>		24a. REC'D BY REGISTRAR <i>DEC 18 '58</i>	24b. REGISTRAR'S SIGNATURE <i>R. C. O.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13519

13528 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cabret</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Republic</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Johns Hopkins</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Republic</i>	
3. NAME OF DECEASED (Type or print) <i>John Percy Howard</i>		f. STREET ADDRESS <i>—</i>	
4. DATE OF DEATH <i>Dec. 7, 1958</i>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 4, 1874</i>
9. AGE (In years lost birthday) <i>84 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
10c. BIRTHPLACE (State or foreign country) <i>Cabret Co., Md</i>		11. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John W. Howard</i>		14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Pitcher</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-36-6076</i>	
17. INFORMANT <i>Ronald Howard - Port Republic, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>—</i>	
(County) <i>—</i>		(State) <i>—</i>	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M., from the causes and on the date stated above ACTUAL SIGNATURE <i>R. Williams</i>		ADDRESS (Street, city or town, state) <i>54 Bernard</i>	
PHYSICIAN'S NAME (Type) <i>Robert de Villareal</i>		DATE SIGNED <i>12/8/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec. 10, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Christ Church Cem. Port Republic - Cabret Co - Md</i>		22d. LOCATION (City, town, or county) <i>(State)</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness & Son - Mutual, Md</i>		24a. REC'D BY REGISTRAR <i>REC 11 58</i>	
		24b. REGISTRAR'S SIGNATURE <i>C. J. S. Kaus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13520

13529 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cabell.		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
		b. STATE Maryland b. COUNTY Charles	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palace Frederick.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newbury.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cabell Nursing Home.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth		First R. Middle Jones	Last 4. DATE OF DEATH December 6 1958
5. SEX Female		5. COLOR OR RACE White	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. B. DATE OF BIRTH March 5 1884		8. AGE (In years last birthday) 74 yrs.	
9. IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. KIND OF BUSINESS OR INDUSTRY Own Home		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNK		14. MOTHER'S MAIDEN NAME UNK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles R. Jones, Newburg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Liver. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 1958 to December 1958, that I last saw the deceased alive on Dec 5 1958, and that death occurred at 2:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Owings Mill DATE SIGNED	
ACTUAL SIGNATURE H. W. Ward		M.D.	
PHYSICIAN'S NAME (Type)			

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/18/58	22c. NAME OF CEMETERY OR CREMATORIUM Christ Ch. Cem.	22d. LOCATION (City, town, or county) Wayside, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Walkers, Md.	ADDRESS	24a. REC'D BY REGISTRAR DEC 9 '58	24b. REGISTRAR'S SIGNATURE C. Hunt & Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 2 '57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13521

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived - If institution, Residence before admission] a. STATE	
Calvert		MARYLAND	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Barstow		b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Hughesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Theodore	Robert	Jones	Dec
4. DATE OF DEATH	Month	Day	Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARR ED <input type="checkbox"/>	8. DATE OF BIRTH
M	C	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	19 Mar 1919
9. AGE IN YEARS (or in months if under 1 year) 39 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
10c. BIRTHPLACE (State or foreign country) Md		11. MOTHER'S MAIDEN NAME Gertrude Jones	
12. CIT ZEN OF WHAT COUNTRY? U.S.A.		Address	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Gertrude Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-16-5222	
17. INFORMANT Alice Jones, Hughesville, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Fracture of neck	
PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 823X		DUE TO auto accident	
Conditions, if any, which gave rise to immediate cause (b)		DUE TO auto accident	
DUE TO (c)			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Lost control of car	
20c. TIME OF INJURY Month, Day, Year 5:20 p.m. 7 Dec 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) road		20f. (City or town) Bryantown, Md	
(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>W. J. Weems</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 7 Dec 1958	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/58	
22c. NAME OF CEMETERY OR CREMATORIUM St Mary's		22d. LOCATION (City, town, or county) Bryantown, Md	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DFC 15 58 DATE	
ADDRESS		24b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13531

Item 2 MARY 36 12-10-58 et

13522

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Washington D.C.</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Federal</i>		c. LENGTH OF STAY IN 1b <i>RURAL and give nearest town</i>		d. STREET ADDRESS <i>3126-3300 N.W. 47x.3 ✓</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Co Nursing Home</i>							
3. NAME OF DECEASED (Type or print) <i>Lethia</i>		First <i>L</i>	Middle <i>E</i>	4. DATE OF DEATH <i>Dec 12</i>	Month <i>12</i>	Day <i>3</i>	Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 2, 1888</i>	9. AGE (In years at birthday) <i>70</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Year Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hospital Records</i>		11. BIRTHPLACE (State or foreign country) <i>Marshall, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James M. Cockrill</i>				14. MOTHER'S MAIDEN NAME <i>Fannie Wilson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cerebral accident</i>						INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Arteriosclerosis</i> (c) <i>Age</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/26/58</i> to <i>12/3/58</i> , that I last saw the deceased alive on <i>12/3/58</i> , and that death occurred at <i>1410 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. W. Ward</i>		ADDRESS (Street, city or town, state) <i>Owings Md</i>					
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>12/3/58</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF <i>12/6/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Congressional Cemt.</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph F. Finch's Son</i>		ADDRESS <i>Washington, D. C.</i>		24a. REC'D BY REGISTRAR DATE DEC 5 '58		24b. REGISTRAR'S SIGNATURE <i>A. J. S. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-troumal permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13523

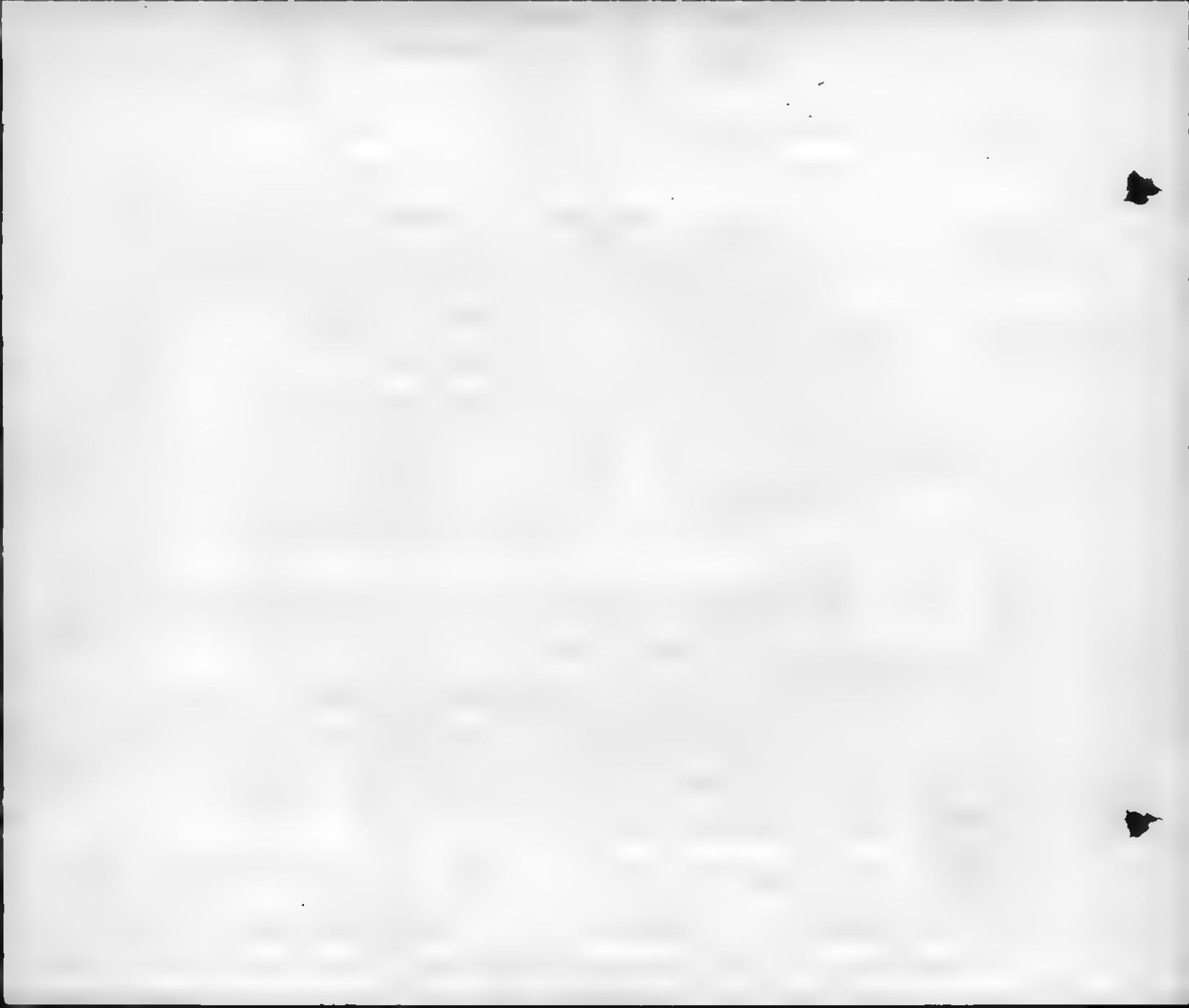
13532 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Calvert Co.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Co. Hospital</i>		d. STREET ADDRESS <i>Prince Frederick</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>ALLEN</i>		First	Middle	Last	4. DATE OF DEATH <i>MacKall</i>	Month <i>12</i>	Day <i>28</i>	Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-24-58</i>	9. AGE (In years last birthday) yrs. <i>5</i>	10. IF UNDER 1 YEAR Months <i>5</i>	11. IF UNDER 24 HRS Days <i>7</i>	12. IF UNDER 24 HRS Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>					
13. FATHER'S NAME <i>Clearance MacKall</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Parker Pr. Fred. Md</i>		Address <i>Clearance MacKall</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Clearance MacKall</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital Heart Defect</i> +! Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Patient Ductus + others</i> DUE TO (c) <i></i> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>S</i>		20f. (City or town) <i>S</i>		(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>Aug 1958</i> to <i>Dec 28 1958</i> that I last saw the deceased alive on <i>Dec 28 1958</i> , and that death occurred at <i>11:00 PM</i> , from the causes and on the date stated above. ACTUAL/SIGNATURE <i>Page C. Jett</i>				ADDRESS (Street, city or town, state) <i>Prince Frederick</i>		DATE SIGNED <i>Prince Frederick</i>			
22a. (BURIAL) CREMATION, REMOVAL (Specify) <i></i>		22b. DATE THEREOF <i>12-29-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Patuxent</i>		22d. LOCATION (City, town, or county) <i>Huntington</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell Prince Frederick</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR DATE <i>JAN 2 '59</i>		24b. REGISTRAR'S SIGNATURE <i>C. E. S. Evans</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13533 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13524

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE Where deceased lived. If institution, Residence before admission a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>H. Beach</i>	c. LENGTH OF STAY IN lb <i>11. Beach</i>	d. STREET ADDRESS <i>11. Beach</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Annie Loretta Maloney</i>		4. DATE OF DEATH <i>12 3 1958</i>	Month Day Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 25 1890</i>
9. AGE in years from birth to date yrs. <i>68</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Edmund H. Saurin</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Shoe store</i>	11. BIRTH PLACE (State or foreign country) <i>Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>3508 Maryland</i>		13. FATHER'S NAME <i>Edmund H. Saurin</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Dyer</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>Theresa Mattie, Baltimore</i>		17. INFORMANT Address <i>3508 Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Alcohol toxicity</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Found dead in house. Had been dead 2 hrs</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Accident</i>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	
20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <i>12/15/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-6-58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>77 Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Bladensburg Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Neal Linnard Home 4812 6th Ave ne</i>		ADDRESS DATE REC'D BY REGISTRAR <i>12-15-58</i>	
		24b. REGISTRAR'S SIGNATURE <i>12-15-58</i>	
VS. A15ME(5) SM 9/55			



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

13534 CERTIFICATE OF DEATH

Reg. Dist. No.

13525

1. PLACE OF DEATH a. COUNTY Cabell MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md b. COUNTY Cabell			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick Life	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION Cabell County Hospital	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret Peterson Martin	First	Middle	Last		
4. DATE OF DEATH	Month Dec.	Day 27	Year 1958		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1870	9. AGE (In years lost birthday) 88 yr.	10. IF UNDER 1 YEAR (IF UNDER 24 HRS.) Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Cabell Co., Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas B. Turner		14. MOTHER'S MAIDEN NAME Patty Alvarez		Address Dr. Thomas B. Turner - Baltimore, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. No	17. INFORMANT Dr. Thomas B. Turner	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 17 day	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) Cerebral Hemorrhage			
DUE TO		(c) Cerebral Hemorrhage			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Park Heights	(County) Baltimore (State) Md.
21. I certify that I attended the deceased from Dec. 10, 1957, to Dec. 27, 1957, that I last saw the deceased alive on Dec. 27, 1957, and that death occurred at 11:30 a.m. from the causes and on the date stated above.					
ACTUAL SIGNATURE	R. V. L. L. M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED 1958
PHYSICIAN'S NAME (Type)	R. V. L. L. M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 29, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Christ Church Cem.	22d. LOCATION (City, town, or county) Port Republic-Cabell Co.-Md	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE O. G. Harkness & Son Mutual, Md.	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE		
		DATE DEC 30 '58	Arthur S. Thorne		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13526

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Carroll Co Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>						
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Everett</i>	4. MIDDLE NAME <i>Everett</i>	5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/4/1775</i>	9. AGE (In years and birthday) <i>83 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>William H. Meade</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Craig</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, if yes, give rank or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Clarbone Meade</i>		Address <i>Holiday Inn</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Produced by coronary artery disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>		
DUE TO (b) <i>Coronary artery disease</i>						<i>3 days</i>		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell at home</i>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>11/130</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> or work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Holiday Inn Carroll Md</i> (County) <i>Carroll</i> (State) <i>Md</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Howard</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>1/24/59</i>		
EXAMINER'S NAME (Type) <i>Howard</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 12, 1958</i>		22c. NAME OF CEMETERY OR CEMATORIUM <i>Miranda Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore County, Carroll Co. Md.</i> (State) <i>Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. J. Workman & Son - Carroll Md</i>		ADDRESS <i>111 W. Pratt St. Baltimore, Md.</i>		24a. REC'D BY REGISTRAR <i>JAN 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>S. Howard</i>		

Replacement: Film 238 - 1-2⁹-59 ams

CERTIFICATE OF DEATH

13536

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY Calvert

C.T.Y. (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN Prince Frederick

MARYLAND

LENGTH OF STAY
(in this place)

5

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Calvert County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Calvert

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Broomes Island

STREET ADDRESS
(If rural give location)3. NAME OF
DECEASED
(Type or Print)

Charles

(Middle)

(Last)

4. DATE
OF
DEATH
(Month) (Day) (Year)

December 20 1958

5. SEX

Male

6. COLOR OR
RACE

White

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Waterman

10b. KIND OF BUSINESS
OR INDUSTRY

Oystering

8. DATE OF BIRTH

8/29/82

9. AGE last birthday

76

yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

William Parks

14. MOTHER'S MAIDEN NAME

Annie Muir

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.) (If Yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

818-12-9223

17. INFORMANT & ADDRESS

Mrs. Marie Williams

Broomes Island

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A)

Coronary thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

5 days

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

Hypertension and

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While
at work Not while
at work

21f. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from Dec 15, 1958, to Dec 20, 1958, that I last saw the deceased

alive on Dec 20, 1958, and that death occurred at M.

from the causes and on the date stated above.

SIGNATURE

K. A. Williams

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

Dec. 23, 1958

NAME OF CEMETERY OR CREMATORIUM

Broomes Island Cemetery

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

DEC 24 1958

REGISTRAR'S SIGNATURE

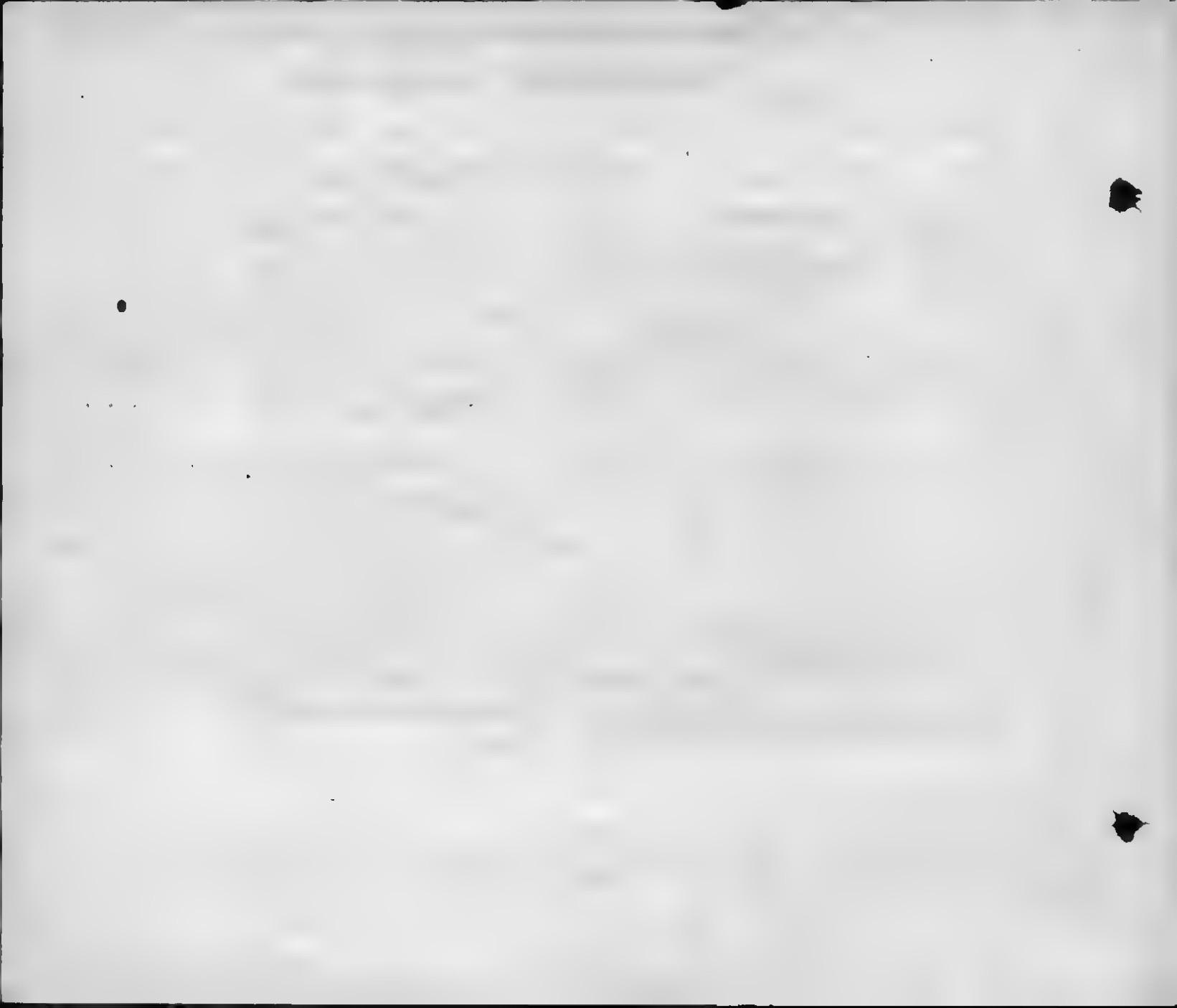
J. S. Kline

25. FUNERAL DIRECTOR'S SIGNATURE

J. A. Williams & Son - Mutual of Md

ADDRESS

DATE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13537 CERTIFICATE OF DEATH

13528

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Calvert County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN lb 2 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown Prince Frederick	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Benjamin	Middle T. Rawlings	Last
4. DATE OF DEATH	Month 12	Day 6	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1867
9. AGE (in years last birthday) yrs. 91	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Fielder Rawlings		14. MOTHER'S MAIDEN NAME Elizabeth Bowen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 760-1-12345 17. INFORMANT Nelson Rawlings - Quantico, Va Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Weenies</i>		INTERVAL BETWEEN ONSET AND DEATH	
(b) <i>Hypertensive C.V.R disease</i>		21 days	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 Oct., 1958, to 5 Dec., 1958, that I last saw the deceased alive on 5 Dec., 1958, and that death occurred at 6:30 A.M., from the causes and on the date stated above.		ADDRESS (Street, City or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>G. J. Weems</i>		M.D. Huntingtown 6 Dec. 58	
PHYSICIAN'S NAME (Type) G. J. WEEMS		Hospital Town MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Ashbury Cemetery		22d. LOCATION (City, town, or county) Barstow - Calvert Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Hackman & Son - Baltimore, Md</i>		ADDRESS	
24a. REC'D BY REGISTRAR DEC 9 '58		24b. REGISTRAR'S SIGNATURE <i>C. L. S. Kneale</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13538 CERTIFICATE OF DEATH

13529

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
<i>Calvert</i>				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Princet Frederick</i>		c. LENGTH OF STAY IN lb <i>3 mon. 28 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Co. Hospital</i>		d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Clarence</i>	Middle <i>Clement</i>	Last <i>Plattengay</i>	4. DATE OF DEATH	Month <i>12</i> Day <i>30</i> Year <i>1958</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 21, 1899</i>	9. AGE (In years (last birthday) yrs.)	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tenant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland U.S.A.</i>	12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>		
13. FATHER'S NAME <i>Clarence Stallings</i>	14. MOTHER'S MAIDEN NAME <i>Bessie Stallings</i>	Address <i>Address</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>44-14-3553</i>	17. INFORMANT <i>Mrs. Emily Jean. Baltimore</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Hypertension c.v.d</i>		
DUE TO <i>Cerebral Hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i>		
DUE TO <i>Cerebral Hemorrhage</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Sept 2, 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) (State) <i>(County) (State)</i>
21. I certify that I attended the deceased from <i>Sept 2, 1958</i> , to <i>Dec 30, 1958</i> , that I last saw the deceased alive on <i>Dec 30, 1958</i> , and that death occurred at <i>12:12 M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>R. de Villalobos</i>	M.D.		ADDRESS (Street, city or town, state) <i>S. Sherman</i>		
PHYSICIAN'S NAME (Type) <i>R. de VILLARREAL</i>	DATE SIGNED <i>12/30/58</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Jan. 1, 1959</i>	22c. NAME OF CEMETERY OR Crematory <i>Mt Harmony</i>	22d. LOCATION (City, town, or county) <i>Mr. Owings Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hutchins Funeral Home, Owings Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>JAN 5 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Albert S. Kline</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG237 1-5-59 et

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
<i>Calvert</i> MARYLAND		a. STATE <i>Md</i>	b. COUNTY <i>Charles</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<i>Home Federal 9 mos</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Co. Nursing Home</i>		d. STREET ADDRESS <i>Indian Head Md</i>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. DATE OF DEATH		Month <i>12</i>	Day <i>20</i>
g. DATE OF DEATH		Year <i>1958</i>	
h. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
i. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Months <i>1871</i>	Days <i>87</i>
j. 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		Hours <i>1</i>	Min. <i>00</i>
k. 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		l. 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
l. 13. FATHER'S NAME <i>George Ziskow Davis</i>		m. 14. MOTHER'S MAIDEN NAME <i>Mary ?</i>	
n. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i>		o. 16. SOCIAL SECURITY NO. <i>—</i>	
p. 17. CAUSE OF DEATH (Enter only one cause, see line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO <i>331X</i> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____</p> <p>INTERVAL BETWEEN ONSET AND DEATH <i>4 mos</i></p>		q. 18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
r. 19. MEDICAL CERTIFICATION <i>Left lady at noon gradually went bad till death</i>		s. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
t. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		u. 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
v. 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		w. 20e. (City or town) <i>58 Lee 20</i> (County) <i>Charles</i> (State) <i>Md.</i>	
x. 21. I certify that I attended the deceased from <i>12/19/58</i> , 1958, to <i>12/20/58</i> , 1958, that I last saw the deceased alive on <i>12/19/58</i> , 1958, and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>H.W. Ward</i> PHYSICIAN'S NAME (Type) <i>Surgeon MD</i>		y. 22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	
z. 22b. DATE THEREOF <i>12/24/58</i>		aa. 22c. NAME OF CEMETERY OR CREMATORIUM <i>Trinity</i>	
bb. 22d. LOCATION (City, town, or county) <i>Newport, Md.</i>		cc. 23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>	
dd. ADDRESS <i>ADDRESS</i>		ee. 24a. REC'D BY REGISTRAR <i>DEC 29 '58</i>	
ff. 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

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